BEFORE THE
COMMISSION ON STATE MANDATES
STATE OF CALIFORNIA

ON REMAND FROM THE CALIFORNIA SUPREME COURT: *County of San Diego* Petitioner, *v.* *State of California, et. al.* Respondent (1997) 15 Cal. 4th 68.	No. CSM R-2046843 *Medically Indigent Adults* STATEMENT OF DECISION (PURSUANT TO GOVERNMENT CODE SECTION 17500 ET SEQ.; TITLE 2, CALIFORNIA CODE OF REGULATIONS, DIVISION 2, CHAPTER 2.5, ARTICLE 7 (Proposed for adoption March 25, 2004)

STATEMENT OF DECISION

On January 28, 2004, the San Diego County Superior Court entered judgment and issued a peremptory writ of mandate, pursuant to the opinion of the California Court of Appeal, *County of San Diego v. Commission on State Mandates, et al.* (September 24, 2003, D039471) [nonpub. opn.], directing the Commission on State Mandates (Commission) to set aside the Statement of Decision of January 26, 2001, and issue a decision that the applicable standards of care forced the County of San Diego to incur $3,455,754 in costs in excess of the funds provided by the State of California, and therefore the State is required to reimburse the County of San Diego in this amount.

In accordance with the peremptory writ of mandate, the Commission hereby adopts this Statement of Decision that the applicable standards of care forced the County of San Diego to incur $3,455,754 in costs in excess of the funds provided by the State of California, and therefore the State of California is required to reimburse the County of San Diego in that amount as set forth in County of San Diego v. Commission on State Mandates (September 24, 2003, D039471) [nonpub. opn.], which is attached and incorporated by reference.

NOT TO BE PUBLISHED IN OFFICIAL REPORTS

COURT OF APPEAL, FOURTH APPELLATE DISTRICT

DIVISION ONE

STATE OF CALIFORNIA

COUNTY OF SAN DIEGO, Plaintiff and Appellant, v. COMMISSION ON STATE MANDATES et al., Defendants and Respondents.	D039471 (Super. Ct. No. 762953)

APPEAL from a judgment of the Superior Court of San Diego County, William R. Nevitt, Jr., Judge. Reversed and remanded with directions.

In *County of San Diego v. State of California* (1997) 15 Cal.4th 68, the California Supreme Court held the Legislature's exclusion of medically indigent adults from the California Medical Assistance Program (Medi-Cal) mandated a new program or service on San Diego County (San Diego) within the meaning of the California Constitution, article XIII B, section 6. The Supreme Court remanded the matter to the Commission on State Mandates (Commission) to "determine whether, and by what amount, the statutory

standards of care . . . forced San Diego to incur costs in excess of the funds provided by the state, and to determine the statutory remedies to which San Diego is entitled." (*Id.* at p. 111.)

On remand, the Commission determined San Diego was not entitled to any reimbursement from the State of California (state) based primarily on the Commission's legal interpretation of certain contracts between the county and medical care providers. San Diego petitioned for a writ of mandate in the superior court seeking to overturn the Commission's decision. The superior court denied the petition. San Diego now appeals. The state and Commission have each filed respondent's briefs supporting the Commission's decision. We conclude the Commission's determination that San Diego is not entitled to any reimbursement is legally and factually unsupported. Based on the Commission's factual findings that are supported by the record, we conclude San Diego proved it was entitled to recover $3,455,754 as reimbursement for the unfunded mandate. We order the superior court to vacate its judgment and issue a writ commanding the Commission to award San Diego $3,455,754 on its unfunded mandate claim against the state.

FACTUAL AND PROCEDURAL SUMMARY

A. *Background*

The background of this case is set forth in detail in *County of San Diego v. State of California, supra,* 15 Cal.4th 68 (*County of San Diego*). We reiterate only those facts necessary for deciding the issues raised in this appeal.

San Diego's reimbursement claim pertains to health care funding for a category of individuals identified as medically indigent adults (known as adult MIP's). At the relevant times, adult MIP's were persons who were financially unable to pay for their medical care, but who otherwise did not qualify under public assistance programs. (*County of San Diego, supra,* 15 Cal.4th at pp. 76-80.) Before 1982, the state provided and funded health care services for MIP's under the state Medi-Cal program. (*Ibid.*) In 1982, the Legislature excluded adult MIP's from Medi-Cal and transferred health care responsibility for these individuals to counties. (*Id.* at pp. 79-80; *Kinlaw v. State of California* (1991) 54 Cal.3d 326, 329.) In response to the legislation, San Diego established a county medical services (CMS) program to provide health care services for adult MIP's. (*County of San Diego, supra,* 15 Cal.4th at p. 80.)

Notwithstanding this transfer of administrative responsibility, the state continued to fund the CMS program from its inception in 1983 through June 1989. (*County of San Diego, supra*, 15 Cal.4th at p. 80.) In doing so, the Legislature created the Medically Indigent Services Account (MISA). (*Ibid.*) Through MISA, the state annually allocated funds to San Diego's CMS program for county residents who fell within the adult MIP category. (*Ibid.*)

However, for fiscal years 1989/1990 and 1990/1991, the state only partially funded San Diego's CMS program. By December 1990, San Diego had exhausted state-provided MISA funds. Faced with this shortfall, San Diego's board of supervisors voted in February 1991 to terminate the CMS program unless the state agreed to provide full funding for the 1990/1991 fiscal year. (*County of San Diego*, *supra*, 15 Cal.4th at p. 80.)

The class action plaintiffs dismissed their action after San Diego agreed to fund the CMS program from its own revenues. (*County of San Diego, supra,* 15 Cal.4th at p. 85.) The matter thus proceeded solely on San Diego's cross-complaint against the state. (*Ibid.*) After an extensive evidentiary hearing, the trial court found that section 6 required the state to fund the entire cost of San Diego's CMS program, San Diego was required to spend at least $41 million in the CMS program in the relevant years, and the amount the state owed San Diego for fiscal years 1989/1990 and 1990/1991 was $21,944,187.40 minus certain future credits. (*Ibid.*) Based on these findings, the trial court issued a peremptory writ of mandate in San Diego's favor. (*Ibid.*)

C. *First Round of Court of Appeal Proceedings*

The state appealed the trial court judgment to this court. (See *County of San Diego, supra,* 15 Cal.4th at p. 85.) We rejected the state's jurisdiction and administrative exhaustion contentions, and affirmed the judgment to the extent it provided that section 6 required the state to fund the CMS program, and that applicable statutes required San Diego to spend at least $41 million on the CMS program in fiscal years 1989/1990 and 1990/1991. (*Ibid.*) However, we reversed the portion of the judgment determining the final reimbursement amount because we concluded the Legislature intended the Commission to initially determine unfunded mandate reimbursement claims, subject to review by the superior and appellate courts. (*Ibid.*)

D. *California Supreme Court Decision*

On review of our decision, the California Supreme Court affirmed our holding that the exclusion of adult MIP's from Medi-Cal imposed a mandate on the county within the

After the state refused to provide additional funding, San Diego notified affected individuals and medical service providers that it would terminate the CMS program at midnight on March 19, 1991. (*Ibid.*)

B. *Initial Trial Court Proceedings*

Responding to San Diego's notice of intent to terminate the CMS program, the Legal Aid Society of San Diego filed a class action on behalf of CMS program beneficiaries seeking to enjoin termination of the program. (*County of San Diego, supra,* 15 Cal.4th at p. 84.) In May 1991, the trial court issued a preliminary injunction prohibiting San Diego "'from taking any action to reduce or terminate' the CMS program." (*Ibid.*)

San Diego responded by filing a superior court action against the state, alleging that, by excluding adult MIP's from Medi-Cal and transferring responsibility for their medical care to counties, the state had mandated a new program and higher level of service within the meaning of California Constitution, article XIII B, section 6, which prohibits unfunded state mandates.[1] (*County of San Diego, supra,* 15 Cal.4th at pp. 84-85.) San Diego requested a judgment declaring that section 6 "requires the state 'to fully fund the CMS program'" and that the state must pay San Diego for all of its unreimbursed costs for the CMS program during the prior fiscal year. (*Ibid.*)

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1 This section provides in relevant part: "Whenever the Legislature or any state agency mandates a new program or higher level of service on any local government, the State shall provide a subvention of funds to reimburse such local government for the costs of such program or increased level of service . . . ." (Cal. Const., art. XIII B, § 6.) We shall refer to this constitutional provision as section 6.

meaning of section 6. (*County of San Diego*, *supra*, 15 Cal.4th at pp. 90-106.) The Supreme Court explained that the "Legislature excluded adult MIP's from Medi-Cal *knowing* and *intending* that the 1982 legislation would trigger the counties' responsibility to provide medical care as providers of last resort under [Welfare and Institutions Code] section 17000."[2] (*Id.* at p. 98.) "Thus, through the 1982 legislation, the Legislature attempted to do precisely that which the voters enacted section 6 to prevent: 'transfer[ ] to [counties] the fiscal responsibility for providing services which the state believed should be extended to the public.'" (*Ibid.*) In response to the state's argument that there was no reimbursable mandate because San Diego retained discretion to determine eligibility for adult MIP health care services and the type and nature of these services, the Supreme Court said that under section 17000 the county had no discretion to refuse to provide medical care to the adult MIP population. (*Id.* at pp. 99-106.) The court recognized, however, that the amount of the reimbursement was limited to the cost of providing the level of "'medically necessary'" care required by section 17000 and other

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2 Welfare and Institutions Code section 17000 (section 17000) provides that "Every county . . . shall relieve and support all incompetent, poor, indigent persons, and those incapacitated by age, disease, or accident, lawfully resident therein, when such persons are not supported and relieved by their relatives or friends, by their own means, or by state hospitals or other state or private institutions."

relevant statutes, which the court referred to as the "statutory standards of care."[3] (*Id.* at pp. 104-106, 111.)

The high court thus remanded the matter for the Commission "to determine whether, and by what amount, the statutory standards of care (e.g., Health & Saf. Code, § 1442.5, former subd. (c); Welf. & Inst. Code, §§ 10000, 17000) forced San Diego to incur costs in excess of the funds provided by the state, and to determine the statutory remedies to which San Diego is entitled." (*County of San Diego, supra*, 15 Cal.4th at p. 111.) In so doing, the Supreme Court disagreed with the conclusion of the trial court and this court that the relevant statutes imposed a minimum funding requirement for the CMS program, and instead held that it was for the Commission to determine the amount of the costs that San Diego incurred in excess of the funds provided by the state. (*Id.* at pp. 106-108.)

E. *Proceedings Before Commission on Remand*

On remand before the Commission, San Diego had the burden of proving its claim that it incurred costs to provide health care services to adult MIP's in excess of the amount received from the state and that the services provided to these individuals through

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3 Although the court declined to define the precise contours of San Diego's statutory duty, it noted that under section 17000 ""medically necessary care"" is "not just emergency care," and "'requires provision of medical services to the poor at a level which does not lead to unnecessary suffering or endanger life and health.'" (*County of San Diego, supra,* 15 Cal.4th at pp. 104-105; see also Welf. & Inst. Code, § 14059.5.) The court further noted that with respect to 1990/1991, the Legislature provided that county-provided indigent health care shall not be required "to exceed the standard of care provided by the state Medi-Cal program." (*County of San Diego, supra,* 15 Cal.4th at p. 106.)

its CMS program were "medically necessary" under the statutes identified by the California Supreme Court. Although in its initial lawsuit San Diego had sought reimbursement for two fiscal years (1989/1990 and 1990/1991), on remand it pursued only costs pertaining to the latter (1990/1991) year.

In its opening papers to the Commission, San Diego submitted declarations showing that the CMS program treated 22,582 adult MIP's during the 1990/1991 fiscal year and that the medical services provided to these individuals met — and did not exceed — the applicable statutory definition of medically necessary care. San Diego further presented evidence that it spent approximately $40.8 million in providing these medical services, and that the state provided San Diego with approximately $19.8 million from the MISA plus additional credits of approximately $6 million, and therefore there was a net shortfall of approximately $15 million.[4]

In response, the state did not dispute that the CMS program services did not exceed the statutory standards of care under section 17000 and the other relevant statutes. But the state urged the Commission to nonetheless deny San Diego's claim, based primarily on evidence that the state had transferred an additional $18,942,077 to San Diego as part of the California Healthcare for Indigents Program (CHIP), and that San Diego "spent at least some, if not the majority, of these CHIP funds on [its CMS program]." The state further argued that the Commission should reject San Diego's claim

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4 We have set forth here only approximate numbers for summary purposes. We will discuss the more precise amounts in Section IVB below.

to the extent that San Diego was claiming reimbursement of mental health treatment costs because these services were not required under section 17000 and San Diego failed to credit the state with an additional $1.3 million in funds received to treat indigent immigrants (referred to as SLIAG funds).

The state also submitted a financial report analyzing San Diego's claim, prepared by the California Department of Finance.[5] This report raised additional grounds for denying San Diego's claim, including: (1) San Diego did not account separately for CHIP and MISA funds in its CMS program; (2) San Diego's managed care contracts with medical providers established that the medical providers accepted the risk that the state would not fully fund the CMS program and therefore San Diego's payments to the providers were unnecessary and unreasonable; and (3) San Diego failed to provide sufficient backup records to support its claimed costs. The financial report (which was unsigned) also charged that the "County might have intentionally destroyed records to prevent an audit of its claim." The state also proffered related supporting declarations of various Department of Finance employees.

In response to the state's additional claims, San Diego filed supplemental memoranda and substantial additional documentary evidence.

Because of the factual and legal complexity of the issues raised, the Commission appointed an administrative law judge (ALJ) to conduct a hearing and review the

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5 The review was not an audit. The state claimed it could not audit San Diego's claim because San Diego could not provide the appropriate documentation, including the necessary expenditure reports.

documentary evidence in the matter. After further briefing, the ALJ conducted a two-day hearing, during which the parties called 11 witnesses concerning the matters in dispute.

After the hearing and additional briefing, the ALJ issued a lengthy proposed statement of decision, recommending that the Commission dismiss San Diego's claim in its entirety. After San Diego objected to the decision on substantive grounds, and both parties and staff noted various calculation errors, the Commission remanded the matter to the ALJ for additional consideration. After reconsideration, the ALJ modified various portions of the statement of decision, but adhered to the initial conclusion that San Diego was not compelled to incur costs in 1990/1991 in excess of the funds provided by the state.

The ALJ's final statement of decision is 20 single-spaced pages with 59 footnotes. Although the length and organization of the decision make it difficult to summarize, the primary basis for the decision was the ALJ's legal conclusion that the costs incurred for the CMS program were not "compelled" because San Diego's contracts with health care providers placed the risk of a state funding reduction on the medical providers, and therefore any payments to these providers in excess of the amount received from the state were not recoverable. The ALJ additionally found San Diego's "commingling" of CHIP and MISA funds precluded a finding that San Diego incurred CMS program expenses in excess of funds provided by the state. In addition to these legal conclusions, the ALJ also discussed at length, and made specific findings regarding, the particular components of San Diego's claim and the various credits to which the state was entitled (which are discussed in more detail below). The ALJ additionally referred several times to the

state's claims that the proof was insufficient to support San Diego's claim, but as discussed below, the ALJ did not ultimately base its conclusion on the adequacy of the proof.

After a brief hearing, the Commission adopted the statement of decision, with two minor modifications to correct calculation errors. In so doing, one Commissioner acknowledged that the issue was an "incredibly difficult one" and that she did not necessarily "understand all the nuances" of the matter.

F. *Superior Court Proceedings Challenging Commission's Decision*

San Diego filed a petition for a writ of mandate in the superior court, alleging the Commission's decision was contrary to law and unsupported by the evidence. (Code Civ. Proc., § 1094.5.) The trial court denied the petition, finding the Commission's decision was proper based on evidence showing San Diego received funds from the CHIP program and therefore San Diego was not required to use its own funds to pay for the CMS program. The court, however, did not identify these amounts or detail the factual basis underlying its conclusion.

San Diego appeals.

DISCUSSION

I. *Overview*

San Diego contends the Commission erred in determining it was not entitled to recover the net costs incurred in funding the CMS program in fiscal year 1990/1991. The state and Commission counter that the Commission's decision may be upheld on three separate grounds: (1) San Diego's costs incurred for the CMS program were not

reimbursable because San Diego transferred the risk of inadequate state funding to the medical providers; (2) San Diego failed to produce competent evidence to support the amount of its claim; and (3) the commingling of the CHIP funds with the MISA funds showed that San Diego did not incur any costs attributable to the statutory mandate.

In examining these contentions, we are governed by the same standards of review as was the trial court. We review the entire administrative record to determine whether the Commission's decision is supported by substantial evidence. (*County of Los Angeles v. Commission on State Mandates* (1995) 32 Cal.App.4th 805, 814; see *Ryan v. California Interscholastic Federation-San Diego Section* (2001) 94 Cal.App.4th 1048, 1077.) This deferential standard requires that we presume the correctness of the Commission's factual rulings and resolve all reasonable doubts in favor of the agency's conclusions. (*Ryan, supra*, at p. 1077-1078.) However, in reviewing questions of law, we apply a de novo standard. (See *Stermer v. Board of Dental Examiners* (2002) 95 Cal.App.4th 128, 132-133; *Duncan v. Department of Personnel Administration* (2000) 77 Cal.App.4th 1166, 1174.) We do not defer to the legal determinations made by the Commission or the trial court. (*Ibid.*)

Before turning to the substance of the parties' arguments, we note that the review of this case was made unnecessarily complicated by the Commission's failure to clearly articulate its factual findings and conclusions. The statement of decision contains numerous inconsistent and ambiguous statements and does not adhere to a coherent organizational structure, rendering the parties unable to agree even as to the nature of the factual findings reached by the Commission. An administrative agency is required to

provide the basis for its conclusions sufficient to permit a reviewing court to determine whether the decision is supported by the facts and the law. (See *Topanga Assn. for a Scenic Community v. County of Los Angeles* (1974) 11 Cal.3d 506, 514-515; see *Dore v. County of Ventura* (1994) 23 Cal.App.4th 320, 327.) Although the resolution of San Diego's claim is factually complex, this did not lessen the Commission's obligation to adequately explain its decision in unambiguous terms that could be reasonably understood by a reviewing court. The complexity of the issues made it even more important that it do so.

Despite the substantial problems with the statement of decision, we must accord substantial deference to the Commission, which has special expertise in the area of unfunded state mandates and in determining the proper amount of reimbursable costs. (See *Hayes v. Commission on State Mandates* (1992) 11 Cal.App.4th 1564, 1596-1597.) We thus shall give the Commission the benefit of the doubt, and accord every possible inference in the state's favor to the statements contained in the statement of decision, unless the inference is contradicted by other expressed conclusions.

Applying these standards, we conclude the asserted grounds for upholding the Commission's decision are legally and factually unsupported. First, we determine the Commission erred as a matter of law in finding that San Diego is not entitled to reimbursement because San Diego was not "required" to pay for the CMS services under the terms of its provider contracts. Second, we conclude the Commission did not reject San Diego's claim on the basis of inadequate proof, and therefore we cannot affirm the decision on that factual basis. Third, although we agree the Commission correctly found

the state was entitled to be credited with the amount of CHIP funds used for CMS program services, we determine the administrative record does not support the conclusion that the total amount of funds received from the state for the CMS program (including CHIP funds) was more than the total amount that San Diego spent on the CMS program. We conclude that, based on the Commission's factual conclusions that are supported by the record, San Diego proved it incurred a net cost of $3,455,754 to pay for statutorily required medical services for adult MIP's. We therefore remand to the trial court and order the court to issue a writ reflecting this determination.

We now explain these conclusions.

II. *San Diego's Contracts with Medical Providers*

The state first contends the Commission's decision is proper based on evidence that San Diego had the "[a]bility" to avoid spending its own funds based on its "innovative and financially prudent CMS program." The state assumes for purposes of this argument that San Diego did in fact incur the increased costs, but maintains that San Diego should be barred from recovering the costs because San Diego was not *required* to pay the health care providers for their services because the terms of the relevant contracts shifted the risk of inadequate state funding to these providers.

A. *Facts Relevant to the Risk-Shifting Argument*

From 1986 through 1988, the state annually provided San Diego with approximately $41 million in MISA funds to pay for San Diego's CMS program. Then in 1989, the state notified the county that it intended to drastically reduce that funding (which it eventually did in 1989/1990 by reducing that amount to $33.9 million and in

1990/1991 to $19.8 million). Partly in response to the anticipated fiscal shortfalls and to ensure adequate access to care for indigent patients, in 1989 San Diego developed a managed-care program to pay for and deliver CMS services, and retained a private contractor, Medicus Corporation, to administer the program.[6]

Under this program, San Diego established three reimbursement pools from which it paid private health care providers, with allocations for each pool capped at the beginning of each fiscal year. These reimbursement pools consisted of the: (1) primary care (clinic) pool; (2) physician/specialty care pool; and (3) hospital services pool. The allocations limited the amount which the health care providers would be paid regardless of the number of patients treated, but the providers potentially benefited because they were entitled to any remaining funds in the reimbursement pools based on the percentage of CMS dollars paid to the individual provider for the contract year. During the year, the hospital providers were paid based on a formula determined by preset point values depending on the type of service.

In 1989, the parties estimated (based on prior use) that CMS professional services would cost $31.2 million, and this amount was divided among the three pools, with the hospital pools funded at $17 million, the physician/specialty pools at $10 million, and the clinic pools at $4.2 million. Based on these amounts, San Diego entered into standard contracts with each health care provider in which the providers agreed to provide

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6 Because San Diego does not operate its own hospitals, it relies on private health care providers to provide necessary health care for its indigent population.

medically necessary care to CMS patients. There were three standard contracts: one for hospital providers, one for specialty providers, and one for clinic providers.

In the 1989 standard hospital contract, the contracting parties assumed that state funding was the exclusive source of funds for the reimbursement pool, but the contract provided that "County or Hospital shall have the right to terminate this Agreement with ten (10) days written notice in the event that State funding for this Agreement is significantly reduced or ceases, prior to the ordinary commencement of the term of this Agreement."

However, with respect to the contract year at issue here (1990/1991), the parties signed an amended agreement extending the term of the 1989 hospital standard contract, but modifying the prior standard contract in several significant ways. First, the amendments added county property tax administration fees as a funding source for the reimbursement pool, expressly "delet[ing] reference to State funding as the exclusive revenue source for CMS," and provided that either party could terminate the agreement upon 60 days' notice. The amended contract further provided that this notice period was not required "if funds for the CMS Program are significantly reduced or not received." The 1990 amendments also specifically added a provision "to address the possible unavailability of property tax revenues" as a source of funding, stating that either party had the right to terminate if the county's "ability to fund this Agreement from property tax administration fees is challenged or repealed."

The 1989 specialty physician and clinic contracts were structured similar to the hospital contracts, and the 1990 amended versions contained similarly broad termination

clauses and provisions making clear that the reimbursement pools would be funded by an allocation of State funds *and* by local property tax administration fees.

According to the former chief of San Diego County Medical Services, Sandra McChesney, the parties entered into the 1990 amended standard contracts in the context of a "severe financial crisis for the County" triggered by the state budget crisis and the state's failure to fully fund the CMS program:

> "Because of the State's delay in adopting a State budget for fiscal year 1990/91 the magnitude of the State's reduction in funding was not fully known at the time that the County negotiated its contract with the hospital pool providers for fiscal year 1990/91. [¶] In December 1990 the CMS program was essentially out of money and the County was contemplating the termination of the CMS program. [¶] In March 1991 the County was sued to prevent the termination of the CMS program. Also, in March 1991 the superior court issued an Order Granting Plaintiffs' Motion for Preliminary Injunction which prevented the County from reducing or terminating the CMS program. [¶] During this State induced crisis, the County was attempting to negotiate a contract extension with the CMS hospital pool providers and to hold together its fragile network of health care providers for the next fiscal year. [¶] . . . [¶] In 1990/91 the County was able to hold together its coalition of health care providers by compensating the providers with County funds as required by court order."

At the Commission hearing, McChesney further elaborated:

> "In 1990/91, we were in really a situation where we weren't sure whether we were going to be able to continue the [CMS] program at all, because the system was set up with these pools and with the reduction of the [state MISA] funding, it threw the whole program in just absolute uncertainty as to what was going to happen.
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> [¶] . . . [¶]
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> "[T]he state budget hadn't been settled, and this was way past July [1, 1990]. So here we are, you know, months into the contract — this was in August I remember — and we still didn't know what the

> State budget was going to be. There was complete uncertainty as to what was happening. We knew that things were going to be cut. The hospitals were basically saying, you know, it's not worth our costs and our hassle to even be involved with you anymore; you know, the administrative costs. It was really a tense time."

B. *Analysis*

In asserting its reimbursement claim, San Diego produced evidence showing that it incurred $32,229,861 in costs for professional services in approximately the same amount as the capped contracts: $17.1 million for the hospital contracts; $10.7 million for the specialty contracts; and $4.2 million for the clinic contracts.

The state countered that the funding clauses in the 1990/1991 standard contracts "capped" the allocations that San Diego agreed to pay the three sets of providers *to the level of state funding* so that San Diego was not required to expend *any* funds of its own on these contracts. The Commission agreed with this argument, concluding that under the relevant contracts the "economic risk" of providing services to the CMS participants "was to be solely borne by contract providers" and therefore state reimbursement "would not inure to the public treasury but, instead, to private service providers who contracted with the County cognizant of economic risk."

This conclusion is not supported by the plain language of the contracts. First, the standard agreements applicable in 1990/1991 do not state that the health care providers assumed the risk of inadequate state funding. Instead, the agreements expressly recognize that the reimbursement pools would be funded by local property tax administrative fees in addition to state funding. Thus, it is not reasonable to read the contracts as providing that the health care providers agreed to accept less than the

estimated funding level if the state failed to provide these funds or that the private providers agreed to bear the risk of a substantial reduction in state funding. Instead, the "risk" that the providers agreed to accept was the financial risk that the costs would exceed the estimated level of funding, which was apparently an acceptable risk because the providers would obtain a potential benefit if the costs were lower than the estimated funding level.

The state argues that the fact that the medical providers and San Diego expressly agreed that the reimbursement pools would also be funded with property tax administration fees is irrelevant because there is no showing that these specific funds were used to pay for the CMS program. However, the point is not whether these precise funds were used, but whether the contracting parties agreed that these funds would be used in the event of a shortage of state funding. The relevance of the property tax provisions in the 1990 amended contracts is that the contracting parties (San Diego and the medical providers) expressly understood that San Diego would look to its own tax revenues to make up any funding loss from the state, negating a conclusion that the health care providers agreed to assume the risk of a shortage of state funds.

We reject the state's alternate contention that San Diego is barred from relying on the property tax provisions in the applicable contracts because it did not raise this specific argument below. The interpretation of a contract is a question of law, and therefore the waiver rule does not preclude us from considering these relevant contractual provisions. (See *Waller v. Truck Ins. Exchange, Inc.* (1995) 11 Cal.4th 1, 24.) The state asserts that this waiver exception rule is inapplicable because the "Commission's interpretation of